Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Parknasilla
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	31 January 2024
Centre ID:	OSV-0001691
Fieldwork ID:	MON-0042755

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Parknasilla is a designated centre operated by Sunbeam House Services Company Limited by Guarantee. Parknasilla offers residential services for up to ten adults with disabilities (both male and female). It is located in Co. Wicklow within walking distance of a large town which provides access to a range of community based amenities to include hotels, restaurants, pubs, parks, shops and shopping centres. The centre comprises of two large houses on the same street. Each resident has their own individual bedroom, decorated to their individual style and preference. Communal facilities are provided including kitchen/dining room, sitting rooms, visitors' room and a TV room. The centre is staffed with an experienced and qualified person in charge. The person in charge is supported in their role by a deputy manager and a team of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 31 January 2024	09:30hrs to 17:30hrs	Kieran McCullagh	Lead

What residents told us and what inspectors observed

This risk inspection was carried out in response to an escalated number of safeguarding notifications submitted to the Chief Inspector of Social Services. Notifications received set out a persistent pattern of peer-to-peer safeguarding and behavioural incidents, constituting a risk of institutional abuse occurring in the centre as a result of failure of the provider to put appropriate measures in place to address the issues of concern.

Parknasilla comprises two homes and is located in a community residential setting in North County Wicklow. The centre is registered to accommodate a maximum of ten residents. On the day of the inspection eight residents were living in the centre with four residents living in each home.

The inspector met with all residents throughout the duration of the inspection and also met and spoke with the Chief Executive Officer (CEO), person in charge, deputy manager and staff members on duty. To gather an impression of what it was like to live in the centre, the inspector observed daily routines, spent time discussing residents' specific needs and preferences with staff, and completed a documentation review in relation to the care and support provided to residents.

The inspector observed the care and assistance provided by the staff team was of a good standard, and they interacted with residents in a kind and supportive manner.

However, from speaking with residents and staff, on the day of inspection it was demonstrated residents were experiencing considerable stress and anxiety as a result of ongoing peer-to-peer safeguarding risks due to incompatibility issues among the resident groups across both houses that made up the designated centre.

Recent case meeting notes also recorded a significant deterioration in one resident's wellbeing over the past fifteen months stating "there are fewer moments in the day where the resident seems happy and content"

Residents living in one home spoke to staff on a number of occasions regarding behavioural incidents and peer-to-peer safeguarding concerns. On the day of the inspection there was one open complaint in relation to noise made by a resident at night time. The inspector met with the resident who made the complaint to discuss the issue they had raised.

The resident said they had been awoken during the night on several different occasions due to a resident shouting and banging on furniture and doors. As a result of this the resident was choosing to wear earplugs in bed to mitigate the risk of being woken up from noise. The resident told the inspector they enjoyed living in the home with the other residents but these issues have been ongoing for a long period of time and lately they had increased. The resident expressed they no longer

wished to live with the resident causing these concerns.

Staff on duty spoke about the residents warmly and respectfully, and demonstrated a rich understanding of the residents' needs and preferences. However, they had concerns regarding ongoing behavioural incidents and peer-to-peer safeguarding concerns.

For example, one staff member told the inspector that a resident presented unwell every morning, which could escalate to the resident continually seeking staff support and reassurance and engaging negatively with their peers, for example, calling them names, shouting and being confrontational. Staff reported that this could last for prolonged periods throughout the day, which in turn, put the resident themselves under significant stress and caused them further anxiety and created a negative atmosphere in the home for the resident group.

The inspector spent time observing the daily routine for one resident. This resident's healthcare and mobility needs had significantly changed over the past number of years. In addition, they had increased mental health support needs, which required increased staff supports and resulted in the resident exhibiting signs of distress and engage in self-injurious behaviours.

Although staff responded in a timely and supportive manner, positive behaviour support plans reviewed by the inspector were out-of-date and, in some cases, inaccurate and therefore ineffective in being able to direct staff in how to support and respond to residents displaying behaviours that challenge and mental health decline.

The inspector reviewed meeting notes from a multidisciplinary team meeting held in December 2023. These notes repeatedly referred to the persistent and ongoing incompatibility issues in the centre and also made reference to staff needing help and support in making life better for residents living in the centre.

Furthermore, recommendations made included; change of location and one-to-one support from staff with a clinical skill set for one resident. These recommendations had been escalated to the senior management team for their review and consideration. However, from speaking with the management team the inspector concluded the provider had not taken any considered or timely action to meet the changing needs of residents or mitigate the safeguarding concerns presenting by implementing the recommendations made.

In the second house, a resident's needs had significantly changed following a dementia diagnosis some years previous. These changing needs were documented in relation to their intimate care supports and falls risks, particularly at night time. In addition, the resident's bedroom location had not been reviewed and they continued to use a bedroom in the upstairs of their home, despite a known risk of falls and requirement for supervision. However, the provider had not responded to the assessed known needs of this resident and were continuing to put in place sleep over staff, which was not effectively supporting the resident. This was resulting in episodes of incontinence and a high risk of falls due to lack of supervision and

support.

In addition, another resident in this home was due to transition to an alternative living accommodation. They had been informed of this transfer and had visited their new potential home a number of times as part of the transition process. However, in recent weeks the provider had made a decision to not progress with this transition plan. At the time of the inspection, it was not demonstrated that the resident or their family had been made aware of this decision with the resident informing the inspector that they were looking forward to moving to a new home. This demonstrated the provider's ineffective lines of communication and consultation with residents to ensure their rights were upheld.

The inspector met with the CEO who acknowledged there were ongoing incompatibility issues within the resident group and that this was adversely impacting on residents' safety and wellbeing. The inspector also met with the person in charge and deputy manager who also confirmed their concerns about the ongoing incompatibility issues presenting in the centre and had in turn, raised these concerns and the ongoing incompatibility situation to the provider.

While it was known and acknowledged that residents required additional supports the provider had not made suitable arrangements to the staffing in the centre to respond to residents' needs and were continuing to assign sleep over staff to work in the centre. In response to these concerning findings the inspector took the unusual step of issuing an urgent action to the provider, requiring the provider to review the staffing and supervision arrangements for residents at night time. This is further discussed in the capacity and capability section of this report.

Provider-led audits carried out in the centre and the centre’s oversight arrangements were not comprehensively identifying or addressing the risks presenting in the centre and therefore the provider had not put in place tangible and time-bound plans in place to address the key issues or drive service improvement.

The incompatible resident group, high frequency behavioural incidents and peer-to-peer safeguarding concerns meant residents' assessed needs were not being fully met in accordance with their assessed and changing needs. Furthermore, the inspector was not assured that the management systems were effective in ensuring that the service provided was safe and appropriate to meet the entirety of residents' assessed needs.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents' lives.

Capacity and capability

This unannounced inspection highlighted significant concerns with the governance

and management of this centre and the impact poor oversight arrangements were having on the care and support provided to residents. This inspection concluded that the provider was not demonstrating that they had the capacity or capabilities necessary to offer a quality service to all residents.

Previous inspections of this centre had demonstrated poor compliance and although the provider had put in place some actions to address the non-compliances found, this inspection concluded that they were failing to effectively address the underlying issues of incompatibility in the centre. As a result, residents were continuing to experience a poor quality of life. In addition, some of the commitments and actions from previous inspections identified the requirement for some residents to transition to a more suitable living arrangement. This inspection found these plans had not come to fruition.

Residents in this centre were supported by a familiar staff team who reported to a deputy manager and a person in charge. However, the night-time staffing arrangements required review by the management team to ensure they were sufficient to deliver a safe service for residents.

On the day of the inspection it was identified that the provider had failed to put in place appropriate staffing arrangements, in line with resident's changing needs during the night time. Despite recorded meeting minutes, staff notes, provider-led audits and numerous incident reports outlining high levels of safeguarding concerns in the centre, the provider had not taken any considered or timely action to meet the needs of residents and mitigate the safeguarding concerns presenting.

Due to the ineffective night time staff support and supervision arrangements the inspector took the unusual step of issuing an urgent action to the provider, requiring them to put in place appropriate night time staffing resources which could meet the assessed needs of residents.

The provider, in response to this urgent action, put in place one waking night staff in each residential home that made up the designated centre, commencing the night of the inspection. While this was a responsive action taken by the provider, it had come on foot of an inspection of the centre and direction by the regulator.

This in turn raised concerns about the provider's capacity and capability to effectively manage the quality and safety of care provided in the centre and demonstrated a consistent failure to protect residents, raising concerns regarding the fitness of the provider.

While the provider had self-identified a number of concerns through these regulatory required six-monthly provider-led audits, corrective action had not been taken by the provider to ensure risks were minimised for residents. Therefore, the inspector was not assured that the provider had the capacity and capability to make the necessary changes or understood the impact and seriousness of these safeguarding concerns on residents living in the centre.

Overall, the centre's governance and management systems were ineffective and needed considerable review because of the lack of responsiveness to the provider's

own internal audit and review processes, the findings on inspection, the negative impacts on the quality and safety of residents' lives and the significant improvements required.

Regulation 15: Staffing

There was a staff roster in place and it was reflective of the staff on duty on the day of the inspection. The provider ensured continuity of care through the use of an established staff team and a number of regular relief staff. However, staffing levels in the centre required a comprehensive review to ensure that the number, qualifications and skill-mix of staff is appropriate to the number and assessed needs of the residents.

For example, some residents required supports at night time to prevent personal injuries related to falls, support when in a heightened and agitated state during the night time and personal hygiene and intimate care supports. The provider had failed to put in place staffing arrangements to meet the needs of those residents and were continuing to assign sleep over staff to work across both homes that made up the designated centre.

The ineffective staffing arrangements were resulting in residents experiencing a poor quality service resulting in incidents of incontinence, potential risk of lack of supervision, which could lead to falls and noise and disturbed sleep for residents in their homes.

Judgment: Not compliant

Regulation 23: Governance and management

Comprehensive oversight arrangements are fundamental to the provision of care. The inspector found that the provider had not ensured that residents were in receipt of good quality and safe care due to the combined impact of the longstanding incompatibility and safeguarding concerns and non-compliance with the regulations. As a direct result, residents' lived experience in the centre was poor.

Despite the substantial evidence to demonstrate there were numerous communication channels, oversight arrangements and reporting mechanisms that informed the provider of the situation in the centre, it was not demonstrated that the provider had taken appropriate action to address these risks and ensure a safe service for residents to live.

The provider had carried out six-monthly provider-led audits and an annual report of the service as required by the regulations. The inspector reviewed the latest unannounced audit from September 2023 and found the report accurately identified

the same concerns found on inspection.

However, the provider failed to act on key concerns highlighted in their own reviews by the quality and safety team and there was an absence of a clearly defined and time-bound action plan to address the known risks in the centre.

Judgment: Not compliant

Quality and safety

The inspector found that the quality and safety of the service provided in the centre to residents was significantly compromised due to deficits and risks in relation to the assessment and meeting of residents' full needs, positive behaviour support, safeguarding and resident's rights.

Comprehensive assessments of need assist in determining the residents' requirements to live a fulfilling life and examines key areas in regards to their health, social and personal wellbeing. Overall, the inspector found that the provider had not ensured that residents' needs were adequately assessed or that the arrangements in place to meet their needs were sufficient. This was known, but had not been addressed by the provider. For example, residents' healthcare and mobility needs had significantly changed over the past number of years. However, the provider had not ensured that assessments of need relating to social, personal and healthcare support needs were reviewed in a timely manner.

Behaviour support plans had been prepared for residents, however one plan reviewed by the inspector was overdue review and the other plan was not fully in line with the provider's policy. Following a review of incidents the inspector was not assured that the provider had taken appropriate action to alleviate the causes of behaviours and stress experienced by residents or that the behaviour support strategies used were effective. This is discussed further in the report.

The provider had not ensured that residents were protected from abuse and responsive measures had not been taken by the provider to address ongoing safeguarding and compatibility issues in the centre. Safeguarding plans in place were ineffective and did not prevent the re-occurrence of abuse. For example, one safeguarding plan made reference to the relocation of a resident as a means of addressing ongoing incompatibility issues. However, during the inspection the provider acknowledged that a meeting took place on 19 January 2024 in which it was directed that the relocation of this resident would not be proceeding. This inspection found the provider failed to take responsive action to monitor and address the ongoing safeguarding risks in the centre and as a result residents were continuing to experience a negative lived experience in their home.

Significant improvements were required to ensure that residents were in receipt of a quality service which was operating in a person-centred manner and which was

respectful of individual residents' rights. The provider had not ensured that the centre was operated in a manner that ensured residents had freedom to exercise choice and control in their daily lives, participated and consented to decisions about their care and support. Furthermore, residents were subject to continued and prolonged disturbances during the night time, high frequency behavioural incidents and peer-to-peer safeguarding concerns. The provider had no clear plan or time frames in place to address the issues in order to effectively improve the quality of life for residents affected.

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of residents' records and found residents did have an assessment of need relating to their social, personal and healthcare support needs. However, following review it was found that these were not being reviewed in a timely manner when residents' needs were changing. This was particularly concerning considering the level of support residents required with regards to their changing needs.

For example, one resident's mobility needs had significantly changed since their dementia diagnosis in 2021. Following a review of documentation it was evidenced that the resident's last occupational therapist review was completed in October 2021. This review reported "it appears the resident may be at risk of falling. This is a concern during the night". The resident's bedroom was located on the first floor of the home, which resulted in significant risk to their safety. A request for occupational therapist review had been submitted in December 2023, however the provider had failed to respond appropriately to re-assess the needs of that resident and put in place supports to improve the safety of this resident.

Another resident's healthcare and mobility needs had significantly changed over the past number of years. However, following review the inspector noted the assessment of need required review to ensure it was up-to-date and reflective of the changing needs of the resident to ensure critical areas are reviewed in a timely manner. In addition, recent multidisciplinary meeting minutes from December 2023 noted that the multidisciplinary team had recommended a change of location with one to one medical staff would be in the best interests of the resident. The provider was aware that the centre was not meeting this resident's needs, however, they had not determined a time bound plan to ensure this resident's needs were being met.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspector reviewed the arrangements in place to support residents' positive

behaviour support needs. Residents who required supports with behaviours of concern had support plans in place. However, these were not reviewed by the appropriate professionals on a regular basis. For example, one resident's positive behaviour support plan had not been reviewed since December 2020.

A meeting was held with the positive behaviour specialist in August 2023 in relation to the reviewing and updating of positive behaviour support plans for residents. However, on the day of inspection positive behaviour support plans remained inaccurate and ineffective in supporting residents with their positive behavioural support needs.

This was particularly concerning considering the high frequency behavioural incidents that were occurring in the home.

The inspector found that the provider was not providing positive behaviour supports in line with their own policy. For example, the person in charge and deputy manager advised that staff were up-dating and making changes to a number of resident's positive behaviour support plans. However, the provider's policy states "the behaviour support specialist provides oversight on and supports the creation, implementation, monitoring and review of positive behaviour support plans". Furthermore, it stated that staff should make no changes to support delivered in relation to positive behavioural supports. This required review by the provider.

Judgment: Not compliant

Regulation 8: Protection

Residents were experiencing high levels of anxiety and stress in their home as a result of ongoing incompatibility issues.

Safeguarding plans in place were ineffective and did not prevent the re-occurrence of abuse. For example, one safeguarding plan stated that the home the resident lives in "has been deemed not suitable for the person causing harm for several years and as a result, a more suitable location has been identified for the resident to move into". On the day of inspection the inspector was made aware of a meeting that took place in January 2024, in which the provider directed the relocation of this resident would not be proceeding.

The inspector reviewed minutes of meetings in relation to safeguarding concerns and found that the provider did not have in place comprehensive or actionable plans to address ongoing incompatibility issues in an effective manner. Overall, the provider had not taken sufficient or effective steps to ensure that residents lived in a suitable environment that was free from distress and failed to ensure their wellbeing was maintained.

There was a safeguarding policy and procedure document in place, however, the policy did not contain sufficient detail to demonstrate that it was consistent with

relevant legislation, professional guidance and internal best practice and overall, that it contained adequate information to provide clear guidance to staff.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had not ensured that the centre was operated in a manner that ensured residents had participated and consented to decisions about their care and support.

For example, one resident had been informed that they were going to move to a more suitable location in line with their assessed needs. The provider had put in place a transition plan in which the resident had visited the location on a number of occasions. The resident expressed their excitement to the inspector about this move on the day of the inspection.

However, as highlighted in the report, a meeting took place in January 2024, in which the provider directed the relocation of this resident would not be proceeding. The resident had not been consulted with or informed of this decision and the provider had not ensured that the resident participated and consented to decisions made about their care or support.

The inspector found many other examples where the rights of residents were impinged upon and compromised.

A review of adverse incidents and notifications identified that there were high frequency occurrences where one residents' challenging behaviours negatively impacted their peers. These incidents related to one resident engaging negatively with their peers, being aggressively confrontational and disturbing other residents for prolonged periods during the night time.

For example, records reviewed by the inspector evidenced that incidents occurred a total of ten times in December 2023 with a further 17 recorded in the month of January 2024.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Parknasilla OSV-0001691

Inspection ID: MON-0042755

Date of inspection: 31/01/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider has put in place a waking night staff in one residence in addition to the current staffing arrangements of the designated centre to further meet the resident's changing needs and to mitigate the current risks. The PIC has instituted a sleep disturbance checklist that staff complete nightly to monitor the additional staffing in place to ensure the skill mix and staff numbers are sufficient to meet the needs of all the residents in the location. A staff recruitment drive has commenced on week of 25/03/24 to provide support to meet specific identified needs of the resident in order facilitate relocation to an alternative single occupancy dwelling.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A completed housing application was submitted to the local County Council office for the resident who will be transitioning from the designated centre, this was completed on 11/03/24. This is a requirement by the County Council for CAS funding in order for the resident to be considered for alternative accommodation which would better suit their assessed needs. A staff recruitment drive has commenced on week of 25/03/24 to provide support to meet specific identified needs of the resident in order facilitate relocation to an	

alternative single occupancy dwelling.

Furthermore, the provider confirmed a deposit was made on 8.3.24 on alternative accommodation which would meet the assessed needs of the resident. The property identified is a 2 bedroom ground floor apartment close to the current designated centre. The facilities manager will simultaneously explore alternative ground floor properties that may suit the needs of the resident to ensure there is a more than one option available. The process of CAS funding application has been initiated and the provider will send an update every two weeks to HIQA in relation the acquisition of the property.

Upon securing the property a SMART plan will be completed. This will include an O.T., health and safety, facilities assessments and recommendation for modifications of the property to meet the assessed needs of the resident. There is a transition document in place to support the resident to relocate to a new home.

The facilities department has provided an estimated timeline once CAS funding is received and the property is received. The timeline is as follows:

* 4 weeks – Funds to be transferred to solicitor and contracts signed for sale of property
* 4 weeks – Contractor to be secured for works
* 10 weeks – Renovation works [Start to finish, all components]

Once the modifications to the property is complete, the provider will submit an application to register the centre.

The provider has put in place a waking night staff in one residence in addition to the current staffing arrangements of the designated centre to further meet the resident's changing needs and to mitigate the current risks.

The PIC has instituted a sleep disturbance checklist that staff complete nightly to monitor the additional staffing in place to ensure the skill mix and staff numbers are sufficient to meet the needs of all the residents in the location.
For the resident whose needs are changing due to dementia the PIC has made GP referral for a Geriatric assessment with Gerontology Department on 08/02/24. GP confirmed on 22/03/24 - referral has been received by Geriatric department and awaiting date for appointment.
Independent advocacy service contacted for resident. Application sent on 11/03/24 and acknowledgement received on 15/03/24. The advocate attended the location on 27.3.24 re the resident with dementia, and met with PIC, the advocate will return when resident is more able to engage. The advocate estimates they will meet with the resident in approximately 4 weeks. However, if the resident has a positive engagement day the location can staff can contact the advocate and they will attempt to visit sooner.
In order to explore all options, a fair deals application was completed on 13/03/24. Acknowledgement of Application received on 19/03/24. Further information requested on 19/03/24. PIC sent further information requested on 25/03/24 and acknowledgement of information received by Nursing Home central office on 25/03/24.
Nursing home referral made upon receipt of Nursing Home Supports Scheme application in Naas central office. CSAR (Common Summary Assessment Report) application forms in

progress since 19/03/24.
The PIC identified a dementia day service in January 2024. Resident has been encouraged to attend but has declined to date, and this is respected in line with their will and preference.
OT/Physio assessment completed for the resident with dementia on 02/02/24.
Falls assessment included in assessed report. Outcome from falls assessment was that the client is not currently a falls risk.
A clinical case review meeting to discuss the current and future support needs of the resident with dementia took place 14/03/24. Actions following this meeting are being implemented.
Safeguarding plans were reviewed and updated on 25/03/24.
Residents enjoy activities of their choosing away from peers who may be impacting on their emotional wellbeing. Residents are generally out on activities for a number of hour per day. The types of activities include trips on public transport, bowling, going to the cinema, cafes/restaurants, farms, overnight holidays, family events, football matches, concerts. Resident who wish also attend day service, and other residents are engaged in employment.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The resident who has been diagnosed with dementia has had their indidivudal assessments and personal plans reviewed. The majority have been completed and the remainder of their support plans will be finalsied by 07/04/2024. Further assessments will be completed as required for this resident and support plans will be created accrodingly on an ongoing basis.
The resident who is due to transition to a new home, has had their assessment of need reviewed. Invidiaulised support plans for this resident have been updated and all remaining plans will be completed by 07/04/2024
PIC and deputy manager completed an internal audit on all resident's personal profile folders on 12/03/24. Key workers tasked with completing all documentation have reviewed and completed the majority of plans and the reaminder will be fully completed by 14/04/2024.
An OT/Physio assessment was carried out on 02/02/24 and initial recommendations were made on the day of the assessment to support the resident in the location whose needs have changed as a result of dementia regarding the physical environment. To date 6 out of 8 recommendations have been completed. The full findings were received by the PIC from the O.T. and Physio on 14/03/2024,
2 outstanding recommendations reaming as follows:
* An identifiable marker is to be put on the rim of each step leading to the resident's bedroom to ensure they are easily recognizable when using the stairs this will be installed on 30/04/2024.

* A raised toilet seat has been sourced through MDT after meeting on 14/03/24 and awaiting a delivery date.
* Other recommendations such as a bath seat, bedroom lighting, falls assessment, intimate care guidance are completed.
A falls assessment was completed in line with OT/Physio assessment on 02/02/24. It was found that the resident could independently ascend and descend the stairs with staff supervision. To date the resident has no history of falls in the location or in the community.
GP referral made for Geriatric assessment with Gerontology Department on 08/02/24. PIC followed up with GP on a number of occasions. Last contact with GP on 22/03/24 - referral has been received by Geriatric department and awaiting date for appointment.
Fair deals application completed and posted to Naas central office on 13/03/24. Acknowledgement of Application received on 19/03/24. Further information requested on 19/03/24. PIC send further information requested on 25/03/24 and acknowledgement of information received by Naas central office on 25/03/24.
Nursing home referral made upon receipt of Nursing Home Supports Scheme application in Naas central office. CSAR (Common Summary Assessment Report) application forms in progress since 19/03/24 and being completed by residents circle of support and professionals.
Dementia day service identified in January 2024. Resident has been encouraged to attend but has declined to date due to changing needs.
Independent advocacy service contacted for resident. Application sent on 11/03/24 and acknowledgement received on 15/03/24. The advocate attended the location on 27.3.24 re the resident with dementia, and met with PIC, the advocate will return when resident is more able to engage. The advocate estimates they will meet with the resident in approximately 4 weeks. However, if the resident has a positive engagement day the location can staff can contact the advocate and they will attempt to visit sooner.
OT and Physio completed a falls assessment on 02/02/24. Findings determined resident is not currently a falls risk.
The Public health nurse assessed the resident with dementia and has recommended the use new intimate care hygiene products for the resident in line with their changing needs, this is now in place and the PIC has instituted a monitoring chart that staff complete daily.
The PIC has instituted a sleep disturbance checklist that staff complete nightly to monitor the additional staffing in place to ensure the skill mix and staff numbers are sufficient to meet the needs of all the residents in the location.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Multi disciplinary lead was contacted by the PIC and PPIM and has allocated a behavioral practitioner to update the behavior support plans required for residents. This

commenced week of 25/03/2024, The PiC has collated all relevant information requested by the behavioral team, and a meeting will take place between the PIC behavioral practitioner on 04/04/24. The behavioral partitioner has provided a timeline of completion dates as follows:

Residents with changing needs will have their Positive Behaviour Support Plans prioritised for completion by 30/04/2024.

The completion date for the remaining residents that require BSPs is 31/05/2024.

The behavioral practitioner will meet with staff to go through the plans to provide guidance and support beginning with the residents who have changing needs.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Safeguarding plans were reviewed and updated on 25/03/24.
A completed housing application was submitted to the local County Council office in person on 11/03/24. This is a requirement for the resident to be considered for alternative accommodation which would better suit their assessed needs.

The provider confirmed a deposit on 8.3.24 on alternative accommodation which would meet the assessed needs of the resident had been placed. The property identified is a 2 bedroom ground floor apartment close to the current designated centre. The facilities manager will simultaneously explore alternative ground floor properties that may suit the needs of the resident to ensure there is a more than one option available. The process of CAS funding application has been initiated and the provider will send an update every two weeks to HIQA in relation the acquisition of the property.

Upon securing the property a SMART plan will be completed. This will include an O.T., health and safety, facilities assessments and recommendation for modifications of the property to meet the assessed needs of the resident. There is a transition document in place to support the resident to relocate to a new home.

The facilities department has provided an estimated timeline once CAS funding is received and the property is received. The timeline is as follows:

* 4 weeks – Funds to be transferred to solicitor and contracts signed for sale of property
* 4 weeks – Contractor to be secured for works
* 10 weeks – Renovation works [Start to finish, all components]

Once the modifications to the property is complete, the provider will submit an application to register the centre.

The relocation of one resident to a new location would improve the lived experiences of both the resident relocating and the remaining residents in the location and mitigate safeguarding incidents.

The provider has put in place a waking night staff in one residence in addition to the current staffing arrangements of the designated centre to further meet the resident's changing needs and to mitigate the current risks.

The PIC has initiated a sleep disturbance checklist that staff complete nightly to monitor the additional staffing in place to ensure the skill mix and staff numbers are sufficient to meet the needs of all the residents in the location.

Safeguarding policy works in conjuction with a comprehensive safeguarding procedure which contains sufficient detail provide clear guidance to staff. This proceedure was submitted with the compliance plan.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The PIC, and staff will continue to communicate with the resident who was due to transition to a new home in a sensitive manner. All communications to date including the changing of any relocation plans have been completed in a planned and structured manner to support the resident to understand and process. This process occurred during the original planned transition and was well documented in the resident's transition plan.

The resident's family was informed about the cancellation of the planned transition on 2.2.24. Following this the resident was informed in a sensitive manner week of 12.2.24 using communication aids that met the resident's communication needs such as pictures and short sentences.

When plans change it is important that the least amount of stress or anxiety is triggered, as such unless a plan is certain to occur this will not be communicated to the resident. There is a risk assessment in place to support this.

For any new transition the PIC will initially consult the MDT team. The resident will be informed in an appropriate manner and simultaneously the family will be informed.

The PIC has consulted the Speech and Language Therapist on 26.3.24 who has provided communication guidance. The PIC has made a referral with SALT to devise a specific communication plan for the resident in relation to their future living arrangements, in line with their will and preference. This will be incorporated into an updated transition plan for the resident.

The resident's family have been informed of the new plans in relation to transferring to a new home on 27/03/2024, and they will continue to be updated once a month or sooner if there are any relevant updates.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Red	30/06/2024
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	30/06/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery	Not Compliant	Orange	31/08/2024

	of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/08/2024
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/08/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an	Not Compliant	Orange	30/04/2024

	appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/04/2024
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/04/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their	Not Compliant	Orange	31/05/2024

	behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/08/2024
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	31/08/2024
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	02/02/2024
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	02/02/2024
Regulation 09(3)	The registered	Not Compliant	Orange	02/02/2024

	provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			